STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
800 NE 136th Ave Ste 200, Vancouver, WA 98684

Caring Places Management, LLC
Beehive Retirement and Assisted Living Community
401 W Maple St
McCleary, WA 98557

RE: Beehive Retirement and Assisted Living Community License # 2148

Dear Administrator:

This letter addresses Compliance Determination(s) 68192 (Completion Date 11/04/2025) and 65468 (Completion Date 09/12/2025).

The Department completed a follow-up inspection of your Assisted Living Facility on 11/04/2025 and found no deficiencies. Your facility meets the Assisted Living Facility licensing requirements.

The Department found that deficiencies for the following licensing laws and regulations were corrected:
WAC 388-78A-2600, WAC 388-78A-2600-2, WAC 388-78A-2600-2-a

The Department staff who did the on-site verification:
Paul Aube, ALF NCI

If you have any questions, please contact me at (253)442-3013.

Sincerely,

Laurie Anderson

Laurie Anderson, Community Field Manager
Region 3, Unit E
Residential Care Services

Residential Care Services
Investigation Summary Report

Provider/Facility: Beehive Retirement and Assisted Living Community
License/Cert.#: 2148
Compliance Determination #: 65468
Investigator: Paul Aube
Investigation Date(s): 09/11/2025 through 09/12/2025
Complainant Contact Date(s):

Provider Type: Assisted Living Facility

Intake ID: 192556
Region/Unit #: RCS Region 3 / Unit E

Allegation(s):
Quality of Care/Treatment: Facility report of a resident-to-resident altercation in the community.

Investigation Methods:

Sample:	Total residents: 47 Resident sample size: 2 Closed records sample size: 0
Observations:	Identified resident Residents Activities Dining Resident rooms Staff to resident interactions Resident to resident interactions
Interviews:	Identified resident Nursing staff Provider Management
Record Reviews:	Facility policies Progress Notes/Alert Charting Negotiated Service Plans

Investigation Summary:
Quality of Care/Treatment: Facility failed to follow policies and procedures after incident. Facility failed to conduct investigation, notify all appropriate parties. Failed practice identified.

Conclusion / Action:

- [x] Failed Provider Practice Identified / Citation(s) Written
- [ ] Failed Provider Practice Not Identified / No Citation Written

☐ N/A

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You are required to be in compliance at all times with all licensing laws and regulations to maintain your Assisted Living Facility license.

The department completed data collection for an unannounced on-site complaint investigation on 09/11/2025 of:

Beehive Retirement and Assisted Living Community
401 W Maple St
McCleary, WA 98557

This document references the following complaint number(s): 192556

The following sample was selected for review during the unannounced on-site visit: 2 of 47 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Paul Aube, ALF NCI

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 3 , Unit E
800 NE 136th Ave Ste 200
Vancouver, WA 98684

Statement of Deficiencies	License #: 2148	Compliance Determination # 65468
Plan of Correction	Beehive Retirement and Assisted Living Community	Completion Date
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As a result of the on-site visit(s), the department found that you are not in compliance with the licensing laws and regulations as stated in the cited deficiencies in the enclosed report.

Clinton Fridley
Residential Care Services

09/19/2025
Date

I understand that to maintain an Assisted Living Facility license, the facility must be in compliance with all the licensing laws and regulations at all times.

Administrator (or Representative)

9/22/25
Date

WAC 388-78A-2600 Policies and procedures.

(2) The assisted living facility must develop, implement and train staff persons on policies and procedures to address what staff persons must do:

(a) Related to suspected abandonment, abuse, neglect, exploitation, or financial exploitation of any resident;

This requirement was not met as evidenced by:

Based on record review and interview, the assisted living facility failed to follow their procedure after a physical resident to resident altercation occurred in the facility for 2 of 2 residents reviewed (Resident 1 [R1], and Resident 2, [R2]). This failure resulted in an absence and/or delay in reporting to all appropriate parties, a failure to investigate the incident, and placed R1 and R2 at risk for ongoing/additional abuse.

Findings included...

Review of facility policy titled, "Abuse, Neglect and Exploitation," undated, documented that any staff member who has a reasonable cause to believe that an incident of abuse, abandonment, neglect, or financial exploitation of a vulnerable adult has occurred will notify the following departments immediately... In Washington – Department of Social and Health Services (DSHS) and that it is the responsibility of each staff member to immediately contact the department directly regarding suspected or alleged abuse or other improprieties. The policy also documented that a Quality Assurance Investigation report will be prepared for any abuse, neglect or exploitation to determine the circumstances of the event and to determine appropriate preventative measures to prevent similar situations.

During an interview with Staff A, Executive Director, on 09/11/2025 at 09:55AM, Staff A

was asked to discuss the expectations of staff when a Resident-to-Resident altercation occurred in the facility. Staff A stated, “[Staff] should be separating residents and moving them away from other residents if they are agitated. Make sure they are safe. They should do a physical check-in with the resident if there are injuries. Make notifications to the nurse, [Administrator], family, and [the resident’s provider]. Collect witness statements, progress notes, and put [both of the residents] on alert. They should do a state [Department] report, and an Incident Report.” Staff A was asked within what time frame the Department should be notified per the facility policy. Staff A stated, “24 hours. We try to do it right away. My expectation is that it should be right away. But I think the policy says 24 hours. My expectation is that it should happen before the end of their shift.”

Review of R1’s Face Sheet showed that the resident was admitted to the assisted living facility on [redacted]/2024.

Review of R1’s progress notes showed a note written by Staff B, the Resident Care Coordinator, dated 08/25/2025 at 12:30AM. The note stated, “Resident was sitting at the activity table with [their] back towards [the community]. When I heard [R2] yelling out. I rushed out of the nurse’s station and found [R2] pushing [their] right hand against [R1’s] neck and screaming in [R1’s] face. When I saw [R1] reach up and scratch at [R2’s] left side of [their] face. I immediately intervened and removed [R2’s] hands away from [R1’s] neck. [R2] then grabbed at [R1’s] arms holding them down. I asked [R2] to remove [their] hands and to stop. [R2] then struck me in the face twice, screaming at me to stop touching [them]. I explained [to R2 that they were] gripping my arms and I showed [them] that my palms were both open. [R2] continued to scream in my face telling me to go to hell. [R2] then attempted to shove me out of the way to reach around towards [R1]. I calmly asked [R2] to go to [their] room as [R1] continued sitting in the chair. [A caregiver] then came over to assist in redirecting [R2]. While [the caregiver] spoke with [R2], I redirected [R1] to another part of the living room to look over [them] for discolorations or marks. [R1] had red substance [blood] coming down [their] face and had visibly widened eyes that were tearful. [R1] stated [they were] upset and cried. I sat with [R1] on the [couch] while [the Medication Aide] attempted to clean red substance from [R1’s] hands and face. [R2] refused to leave the living area and redirect back to [their] room so we continued to stay and keep residents separated.” Further review of R1’s progress notes showed that there was no documentation of any notification to the R1’s provider, or R1’s family/representative.

Review of R1’s medical record showed there was no Incident Report/Investigation completed by the facility for the incident.

Review of R2’s Face Sheet showed that the resident was admitted to the assisted living facility on [redacted]/2023.

Review of R2’s progress notes showed a note written by Staff B, Resident Care Coordinator, dated 08/25/2025 at 12:33AM. The note was identical (copy and pasted) to the note entered into R1’s progress note dated 08/25/2025 at 12:30AM. Further review

of R2's progress notes showed that there was no documentation of any notification to the R2's provider, or family/representative.

Review of R1's medical record showed there was no Incident Report/Investigation completed by the facility for the incident.

Review of Department records showed a report made by the facility to notify the Department of the incident and report the Resident-to-Resident altercation on 08/28/2025.

During an interview with Staff B on 09/11/2025 at 12:52PM, Staff B was asked to discuss the delay in reporting the altercation to the Department. Staff B stated, "I did not do the state report. I was under the impression that it was going to be done by the medication aide." Staff B then stated, "It wasn't until I sat down later to review notes that I noticed it was not reported, so I reported it."

During an interview with Collateral Contact 1 (CC1), R1 and R2's medical provider, on 09/11/2025 at 12:48PM, CC1 was asked to verify that they were responsible for the medical care of R1 and R2. CC1 confirmed that they were. CC1 was asked if they were notified by the facility of a recent Resident-to-Resident altercation involving R1, and R2. CC1 stated that the facility just notified them earlier that day. CC1 was asked if the facility notified them at the time of the incident, on 08/25/2025. CC1 reviewed their records, which included scanned copies of faxes/notifications from the facility and stated that they received no notifications from the facility for the entire month of August 2025 for R1 or R2.

This is a recurring deficiency previously cited on 12/14/2023, and previous consultation on 10/05/2022.

Statement of Deficiencies	License #: 2148	Compliance Determination # 65468
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Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, Beehive Retirement and Assisted Living Community is or will be in compliance with this law and / or regulation on (Date) 9/12/25 .

In addition, I will implement a system to monitor and ensure continued compliance with this requirement.

Administrator (or Representative) Date 9/22/25